Abbeyfield Loughborough Society Limited(The)

Abbeyfield Loughborough

Inspection report

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	**Inadequate** ●
Is the service effective?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

About the service
Abbeyfield Loughborough is a care home specialising in dementia care. The premises consist of Westfield House, the original part of the home, along with Ingleside House, a new three-storey home. The two parts of the premises are joined by a link corridor and communal garden area. The service provides accommodation and personal care for up to 64 people. At the time of our inspection, there were 57 people using the service.

People's experience of using this service and what we found
People were at risk of harm due to a lack of staff supervision and mitigation of known risks associated with their needs. Staff lacked the knowledge, information and training to ensure the safety of people during distressed behaviours which placed them and others at risk of harm. Staff lacked the understanding and skills needed to effectively support people living with complex dementia.

Staffing levels were not sufficient to meet people's individual needs and keep them safe from harm. Additionally, people did not receive the support they needed to have enough to eat and drink or to maintain their wellbeing and hygiene. People were not consistently supported to maintain their oral hygiene and mitigate risks around oral care.

People and staff were not always protected from the risk of avoidable harm. The provider failed to have systems and processes to ensure lessons were learnt and remedial action was taken in a timely manner to keep people safe. People's medicines were not always administered or managed safely. People were protected from the risk of infections, though some areas of the premises required updating and decorating. The premises did not fully support the needs of people living with dementia.

Care planning documentation was not always detailed with information regarding people's individual needs and did not provide the guidance staff needed to deliver person centred care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Consent had been given by relatives and external agencies without the legal authorisation to do so.

The providers' systems for assessing, monitoring, and improving the quality and safety of the service were not operating effectively. They failed to identify issues we found at this inspection. There was poor oversight of the service to ensure people received safe care and treatment.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 5 April 2023) and there were breaches of

regulations. The provider submitted an action plan detailing what improvements they intended to make.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement and Recommendation
We have identified breaches in relation to risk management, medicines, staffing, consent and management oversight at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Special Measures
The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abbeyfield Loughborough on our website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

Abbeyfield Loughborough

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 inspectors and 2 Experts-by-Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Abbeyfield Loughborough is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Abbeyfield Loughborough is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider had not been sent a provider information return (PIR) prior to this inspection. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We met with 6 people and 2 relatives and spoke to a further 9 relatives by telephone about their experience of the care provided. We spoke with 10 staff including the general manager, 2 assistant managers and care staff. We observed staff interactions with people whilst delivering care and support in communal areas during mealtimes, medicines administration and provision of activities.

We reviewed a range of records. This included 6 people's care records, multiple medicine records and daily care notes. We looked at 3 files in relation to the recruitment and supervision of staff. We examined a variety of records relating to the management of the service, including policies and procedures, quality assurance audits and staff training records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last inspection the provider had not effectively assessed and managed risks to people's health and safety. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People were at risk of improper treatment. One person was described in their care plan as becoming 'nasty' with staff and required 3 staff to support them during personal care. On the day of our inspection, 4 staff had assisted the person to have personal care. A staff member showed us bruising and marks on their arms and described how the person had kicked, punched and scratched staff during this process. The person did not have any information recorded regarding if physical interventions had been approved as appropriate and behaviour charts failed to evidence how staff had provided personal care. Staff had not been trained to complete physical interventions. This put people at risk of inappropriate use of physical interventions.
● A second person experienced frequent distress. Their care plan stated they were at risk of harm including head injuries through crawling around the floor in communal areas, and therefore furniture around them should be removed. We observed the person on the floor, crawling around an armchair in a communal area. The person was not supervised. Staff shared concerns that the person had been found in a number of communal areas, including wedged behind furniture and in a communal toilet, and frequently bruised their head. Despite these known risks, there was no additional personalised staff support in place to mitigate these for this person. This meant people were at risk of harm due to a lack of supervision and mitigation of known risks.
● A third person was described as requiring staff support to shower and maintain personal hygiene. Their daily care records showed they frequently declined this support and had not been supported to have a shower for the month of September 2023. Staff told us they did not know what to do if the person regularly declined care as they 'were difficult to manage and could become nasty' therefore staff did not attempt to provide this. This placed people at risk of harm from failing to receive the personal care support they were assessed as requiring.
● People were at risk from their anxieties and distressed behaviours. Records did not include how staff should support people to reduce their anxieties or distress when this reached a crisis and mitigate risk of harm to self and others. When a person exhibited anxiety or distress staff had not consistently recorded the details of the behaviour exhibited, any potential causes, duration, how staff supported them and the impact this had.

● There was no system in place to de-brief with staff after incidents of physical or psychological harm to implement systems to avoid repetition and ensure lessons were learnt.
● People were at risk of harm from moving and handling techniques used by staff. During the inspection we observed 2 staff members pulling a person up by their clothing in order to use standing equipment. A staff member told us this was because they did not think the person was able to use the equipment provided. A second staff member told us they were not sure what equipment the person should be using as care records lacked clarity. This put people at risk of falls and injury.
● Some relatives told us they were concerned some staff lacked the training to help people to mobilise safely. A relative told us, "[Name] uses equipment and the physio came out and found staff did not know what to do with it." A second relative told us, "Some staff are not trained in using the equipment so [Name] has to stay in a chair."
● We found multiple gaps in people's repositioning records where they required support to change their position. A staff member told us, "Repositioning checks can be very late as we don't always have enough staff to do this." This put people at risk from poor skin integrity and pressure wounds.
● Accidents and falls were audited but were not consistently analysed or reviewed to demonstrate if lessons had been learnt and actions taken to mitigate future risk of harm for people.

The lack of proper risk assessment, risk management plans and care plans exposed people using the service to risks of avoidable harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People's needs were not consistently met due to the number of staff deployed. We observed the deployment of staff failed to identify people's individual needs that impacted on the level of staffing required to keep them and others safe.
● Staff deployment failed to include the requirement for consistent supervision of a person to protect them from known risks and the additional staff support required for when people became distressed.
● During our inspection visit, we observed 4 staff were required to support 1 person, a staff member administered medicines and another staff member monitored the communal lounge and served breakfast. This left only 1 other staff member to meet people's needs. Additionally, a high number of people required 2 members of staff to support with their mobility needs around the service. We observed people were left with breakfasts and drinks in their rooms that were cold and not consumed. This left people at a risk of harm from not being appropriately supervised or supported.
● A provider audit completed in September 2023 identified the current staffing level was not sufficient to meet people's needs. The provider had failed to identify any remedial actions or measures taken in response to this finding.
● Staff told us there were not enough staff. Comments included, "We don't have enough staff for people to go outside in the garden as we can't spare anyone to supervise. This makes people frustrated and increases their distress," "It is difficult in the morning. At times people get forgotten in their rooms" and "We don't have enough staff to give people the supervision they need and incidents do happen as a result."
● Relatives provided mixed views of staffing. Some felt there had been an improvement in staffing levels recently, whilst others felt staffing remained a concern. Comments included, "Staff are kind but lots of people need 2 staff and more support. My family member needs help to use the toilet and sometimes it's too late before staff can help. Staff have told [Name] to go in their continence pad," and "There have been a lot of staff shortages and use of agency staff, though this has improved lately."

The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to support people to stay safe and meet their needs. This was a breach of

Regulation 18 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. The provider requested references from previous employment and the employees' Disclosure and Barring Service (DBS) status had been checked. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● Staff received safeguarding training and understood the signs of abuse and how to report any concerns. However, they were not confident the provider took timely action to keep people safe from harm. A staff member told us, "People are at risk from harm as staff do not support them safely whilst providing care. Lots of people have bruises up their arms as a result of this but no action is taken."
● For example, a person had been found wedged behind furniture and in communal toilets due to a lack of supervision. Several staff described how the person sustained minor head injuries as a result and was at constant risk of harm. The provider had failed to take any timely action to increase personalised support to safeguard this person.
● A relative told us, "[Name] had unexplained bruising and I raised it with a senior staff member over a month ago. No one has come back to me to explain how this happened."
● The provider had failed to ensure timely action had been taken to safeguard people in response to a sexual incident between 2 people. They had failed to notify external agencies and had advised staff to be vigilant and increase supervision, despite making no changes to staff deployment to support this. This meant people were not adequately safeguarded from harm.

The provider failed to follow their safeguarding adults' procedures to safeguard people from abuse and improper treatment. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People were at risk of not receiving their medicines as prescribed. When people were prescribed 'as required' (PRN) medicines protocols were not always in place to support staff to understand the reason the medicine should be administered. This meant staff did not have the information required to ensure safe medicine administration.
● Records to maintain a stock count of medicines were not consistently completed which meant staff were unsure of how many tablets were in stock for some people. We found 2 incorrect stock counts which indicated people had not received their medicines as prescribed.
● Where people had been identified as requiring their medicines to be administered covertly (hidden in food or drink), care plans failed to demonstrate that these decisions had been made in people's best interests.
● A person required staff to support them in managing their diabetes. We found records failed to demonstrate what, if any, staff actions were when the person's blood sugar levels were unusually high. Staff told us they would monitor and re-check but medicine and care records failed to evidence this. This put the person at risk through poor monitoring of their health condition.

The provider had failed to ensure the proper and safe management of medicines. This was a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of

infection.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. However, some areas in the Westfield House required updating and redecorating. For example, the storage area for cleaning products was water damaged and dirty.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The home was open for visitors with no restrictions in accordance with the current guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our inspection on 10 November 2021 we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Consent had been given on behalf of people by others that did not have the legal authorisation to consent on behalf of the person. For example, people had authorisations by the GP for medicines to be administered covertly. This was not supported by any best interest processes.
● Where people had conditions attached to their DoLS authorisations, records failed to evidence these were being followed. For example, conditions around the provision of activities and the monitoring of distress were not consistently complied with.
● Staff demonstrated a lack of understanding of the MCA which resulted in inconsistency in approaches where people who lacked mental capacity frequently declined care.

The provider had failed to ensure care and treatment was provided with consent of the relevant person and to act in accordance with The Mental Capacity Act 2005. This was a continued breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were at risk of harm through insufficient fluids and nutrition. We observed 2 people who required staff support to eat and had untouched breakfast in their rooms that was cold and congealed. We reviewed both people's daily care notes and saw 1 person had received a fresh breakfast following our intervention, whilst the other person was recorded incorrectly as having consumed their breakfast. This put people at risk of poor nutrition.
● People's care records failed to demonstrate they were having sufficient fluids each day. For example, a

person was reliant on staff to provide them with sufficient fluids. Their fluid intake over a 6 day period in September 2023 ranged from 200mls to 1250mls per day. A health care professional had identified a health concern and advised staff to increase the person's fluid intake. Despite this advice, the person was still only consuming under 900mls per day and did not have a target daily fluid intake to guide staff. Additionally, the person's fluid intake was not totalled each day, meaning staff were unaware of how much fluid they had consumed. This put the person at risk from dehydration.
● A second person had been identified at risk from poor hydration and required daily monitoring. Their fluid monitoring records were not consistently completed by staff and frequently showed a low fluid intake. This put the person at risk from dehydration.

The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks. This was a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● People were at risk of harm as staff did not have the skills, knowledge, information or support required to be effective in meeting their needs.
● The provider marketed Abbeyfield Loughborough as a dementia specialist service and supported people with complex dementia, including distressed behaviours. However, staff had only completed a basic on line course in dementia awareness and positive behaviour support. This did not give them the skills they needed to keep people and others safe from harm. A staff member told us, "Staff are inconsistent in their approach and response to people which triggers people's distress. We have only had very basic training which in no way meets people's intense needs here." A second staff member told us, "I did the dementia training on line modules. I would say it was very basic and doesn't really cover what needs people have here, which are more complex."
● Staff were not provided with sufficient training, information or support to respond to people who could become very distressed. Care records lacked robust positive behaviour support strategies to guide staff on approved interventions and responses. This led to inconsistency in approaches and staff and people sustaining injuries as a result.
● We observed staff lacked insight into complex dementia care. Throughout our inspection visit, several people became disorientated and distressed. Staff attempted to reassure people but were unable to implement appropriate engagement and intervention in response to this. Additionally, terminology used by staff in care recordings referred to people 'becoming nasty' when they were distressed. This demonstrated a lack of insight and understanding of the needs of people living with advancing dementia.
● Staff did not receive any support post incident where a person's distress had resulted in harm to themselves or staff. The provider had failed to have systems in place to de-brief with staff after incidents of physical or psychological harm to implement systems to avoid repetition.

The provider had failed to ensure that staff received training, and supervision as is necessary to enable them to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they began to use the service. People and relatives were involved and consulted during this process. A relative told us, "We were involved in developing the care plan but haven't had much involvement after admission. Staff do keep us informed if anything happens or changes to the care."
● Assessment information formed the basis of people's care plans. However, this did not always result in

best practice being followed. For example, nationally recognised best practice guidance around positive behaviour support was not being followed. Care plans did not always recognise people's individual lifestyle choices or protected characteristics.
● Assessments did not provide sufficient information or guidance around people's anxiety and distress, communication or mobility needs.

Adapting service, design, decoration to meet people's needs
● The design of the 2 premises was not always meeting people's needs. There was minimal signage to aid orientation for people living with dementia.
● The newly built premises, Ingleside, lacked any personalisation or stimulation within communal areas. There were areas of the older premises, Westfield, that required updating and redecoration to meet the needs of people living with dementia.
● People who required support were unable to access the rear courtyard garden on a daily, regular basis as there were not enough staff to supervise. One staff member told us, "People rarely go out as we have been told there has to be a staff member with them and there isn't one for the lounge and outdoors. People's lifestyle needs are not really explored which leads to frustrations for them." A relative told us, "There is one thing which I think is sad. People don't get to go out in the garden and enjoy it each day. Staff do not have the time to do this."
● The home had adapted bathrooms, dining rooms with suitable furniture to support people with limited mobility.
● People had access to equipment that enabled their independence and ensured their physical needs were met, for example, bath seats, walking aids and wheelchairs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's oral healthcare needs were not always met. We found a person with dentures that appeared to be too large for their mouth. They had turned these around and moved them to the back of their mouth which presented a significant choking risk. We alerted staff who removed these from the person's mouth but did not return with them, leaving the person without teeth. Additionally, care plans failed to evidence where people had received support to maintain their daily oral healthcare.
● During our inspection, a GP visited the service to undertake a weekly ward round. Care records showed people were supported to access the GP and other healthcare services, such as speech and language therapy.
● Staff did not always act on or seek timely guidance from healthcare professionals. For example, a healthcare professional had instructed staff to increase daily fluids for a person but this had not been actioned. A person was continually falling out of their bed and sustaining head injuries. Despite this occurring on numerous occasions, the provider had failed to undertake timely assessments or referrals which put the person at risk of harm.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection we found the provider's systems for monitoring the quality and safety of the service were not operating effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider's quality monitoring systems remained ineffective. There was no registered manager in post. The general manager told us they were always at the service overseeing staff and care and were supported by 2 assistant managers and were waiting for a newly appointed manager to start employment. Evidence we found on this inspection identified significant failings in the management and oversight of the service.
- Audits and checks were not effective in identifying the concerns we found at this inspection. This put people at risk of harm through unsafe care and treatment.
- Systems and processes had failed to identify insufficient staffing being deployed which put people at risk from not having their needs met and not receiving person centred care.
- Systems and processes were not in place to ensure risks had been identified and mitigated, including risks associated with people's distressed behaviours and mobility. Concerns are recorded within the safe domain in this report. This put people and others at risk of harm.
- Systems and processes were not in place to ensure staff were sufficiently trained and supported to meet people's needs safely and effectively.
- Systems and processes were not in place to ensure compliance with the Mental Capacity Act. Concerns are recorded within the effective domain in this report. This put people at risk of not receiving care in line with their best interests.
- Systems and processes failed to identify people's care plans and care records were not accurately completed within electronic care planning and were not fully reflective of people's needs.
- Staff expressed concerns around the management and governance of the service. A staff member told us, "I raised concerns to the managers about a person as I felt they were not safe and needed more care. I was ignored and the person continues to have injuries and be at risk." A second staff member told us, "Managers rarely come out of the office to walk the floor or talk with us or people."

● The provider did not always act in line with the duty of candour. We found that a sexualised incident had not been referred to the local authority safeguarding team or CQC. Additionally, we found a relative had not been informed that a person had sustained a head injury due to staff poor practice during assisted moving.

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed feedback from relatives around the management and governance of the service. Comments included, "I think staff are approachable and handle things well," "Staff are approachable but information is not always followed up or passed on" and "Staff are friendly and attentive; I don't see much of management. Sometimes I don't know what happens as staff seem to be chasing their tails half of the time."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture of the service did not consistently support staff to provide person centred care or achieve good outcomes for people. For example, a staff member told us, "Things can get missed, like forgetting to give someone a cup of tea and repositioning can go over as we are so busy." We found several examples supporting poor outcomes for people around support with distressed behaviours and people's safety.
● The provider had systems in place to take account of staff, relatives and people's opinions of the service. Relative meetings were managed and led by relatives and information was shared with staff, including any requests or suggestions for changes or improvements.

Working in partnership with others
● Managers told us they worked closely with the GP and health care professionals to make sure people's health needs were met.
● Some relatives felt staff worked with them and kept them informed, whilst other relatives felt information and communication was not consistently provided.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure care and treatment was provided with consent of the relevant person and to act in accordance with The Mental Capacity Act 2005.

The enforcement action we took:
Urgent notice of decision to impose conditions on the providers' registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of proper risk assessment, risk management plans and care plans which exposed people to risks of avoidable harm. The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:
Urgent notice of decision to impose conditions on providers' registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to follow their safeguarding adults' procedures to safeguard people from abuse and improper treatment.

The enforcement action we took:
Urgent notice of decision to impose conditions on the providers' registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate

	systems and processes were in place to assess, monitor and improve the quality and safety of the care provided

The enforcement action we took:

Urgent notice of decision to impose conditions on the providers' registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to support people to stay safe and meet their needs

The enforcement action we took:

Urgent notice of decision to impose conditions on providers' registration